

INCIDENT/ACCIDENT ANALYSIS FORM

Accident # _____

| Employee Information: | Areas of Concern | Employee Injury Results |
|--------------------------------------|---------------------------|---|
| Employee Name: _____ | Slips/Trips/Falls | Has the worker sought medical attention: Y / N Date: _____ |
| Location: _____ | Lifting / Overexertion | What parts of the body were injured: _____ |
| Date of Injury: _____ Time: _____ | Gate issues | _____ |
| Date Reported to Supervisor: _____ | Bloodborne Pathogen ex. | _____ |
| Dept: _____ | Restraint Issues | _____ |
| Occupation of employee: _____ | Chemical Exposures | Claims Cost Control - Have all parts of faulty equipment, machinery or other evidence associated with this accident been preserved? _____ YES _____ NO - Explain _____ _____ _____ |
| | Car accidents / transport | |
| | Falling objects | |
| | Repetative Motion | |
| | Struck by Object | |

Description

1. Describe the incident/accident. Include the machine, object or substance involved and explain exactly what the injured worker was doing. _____

2. What did each co-worker or witness say about the incident/accident? (If necessary, attach additional sheets). _____

3. If pain gradually occurred, how does the employee relate the problem to work? _____

4. Have other employees had injuries, accidents or near misses at or near this job site? If so, when, where and how are they related to this incident/accident? _____

5. If an unsafe act(s) was a cause of this incident/accident, why was the unsafe act committed? _____

6. If an unsafe condition(s) was a cause of the incident/accident, why did the condition exist? _____

7. If an organization cause(s) was a cause of the incident/accident, why did the cause exist? _____

cc: Reviewing Manager
 Safety Committee

Signature of person filling out the form: _____ Date: _____

Signature of Supervisor _____ : _____ Date: _____